HORIZON EYE PHYSICIANS

HIPAA Patient Consent Form

In response to the misuse of Personal Health Information, the Department of Health and Human Services has established a Privacy Rule to ensure your Personal Health Information is kept private. This rule was also established in order to provide a standard for healthcare providers to obtain their patients' consent for the use and disclosure of health information about the patient in order to carry out treatment, payment, or other healthcare operations.

We want you to know that we respect the privacy of your personal medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel need your Personal Health Information to provide health care that is in your best interest.

We support your full access to your medical records. You should be aware that we may have indirect treatment relationships with you that include but are not limited to laboratories, pharmacies, and other medical offices. As such, we may need to disclose your Personal Health Information for purposes of treatment, payment, and/or healthcare operations. These outside entities do not necessarily need to obtain your consent for this Communication.

You have the right to refuse to consent to the use of disclosure of your Personal Health Information. This refusal must be made in writing. Under the HIPAA law, we have the right to treat you if you choose to refuse disclosure of your Personal Health Information. If you give consent to disclose your Personal Health Information, by signing this document, you can at some future time request to refuse future disclosures of your Personal Health information. This refusal must be made in writing. However, you may not revoke actions that have already been taken which relied on this or previously signed consent.

Please speak with our Administrative Staff if you have objections to this consent. Please list below any individual to whom we may discuss your Personal Health Information with. (I.e. spouse, family member, friend, etc.)

Name of person who can receive your medical information:

_____

Patient Signature:

_____

Date:

_____